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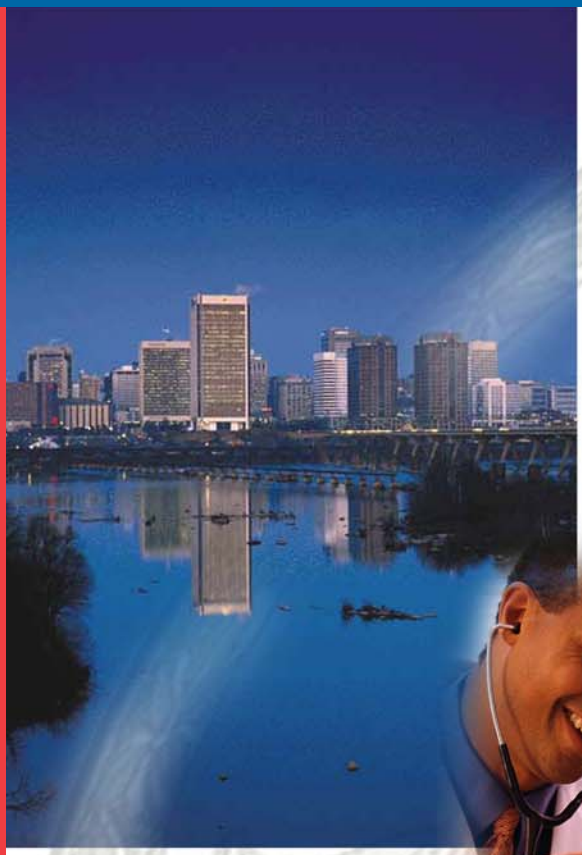

Commonwealth of Virginia

Clinical Study

FAMIS

FAMIS

Covering Children With Affordable Health Insurance

We don't provide healthcare... we make it better.

CY 2004

Introduction and Overview FAMIS Studies CY 2004

Introduction

The Department of Medical Assistance Services (DMAS) is the state agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the Social Security Act and the Virginia State Child Health Insurance program (SCHIP), under Title XXI of the Social Security Act. The SCHIP program in Virginia is known as the Family Access to Medical Insurance Security (FAMIS) program. Both of these programs are financed by federal and state funds, are administered by the state according to federal guidelines, and include coverage of medical services for eligible Medicaid and FAMIS enrollees.

The Department oversees the development, implementation, and operation of two managed care programs for the Medicaid and FAMIS enrollees. These include the MEDALLION program, a primary care case management program (PCCM) and Medallion II, a program that delivers care through managed care organizations (MCOs) under contract with the Department.

Under the MEDALLION program, primary care providers (PCPs) are paid directly by the Department on a fee-for-service basis plus a per-member-per-month case management fee for the coordination of care. The Medallion II Program is a full risk program in which recipients are enrolled in a MCO that operates a provider network, negotiates fees with providers, and has a system of utilization review and quality oversight. Enrollment in the Medallion II program is mandatory in the portions of the state in which the Medallion II program operates, except for certain categories of recipients, such as children in foster care, those in nursing homes, those in state mental health facilities, and areas where the Department has contracted with only one MCO. In areas with one MCO, individuals may elect to be enrolled in the MEDALLION program. Children enrolled in Virginia's FAMIS program, are enrolled in the managed care programs.

FAMIS was created in 2001 to assure that children could gain access to health insurance in the new program. FAMIS covers eligible children (who are not covered by Medicaid, are not covered under health insurance, and are not members of a family eligible for coverage under the state employee health plan) from birth through age 18 in families with a gross income at or below 200% of the federal poverty level. PD94, the Medicaid expansion group, covers uninsured children age 6-18 years of age not eligible for traditional Medicaid whose family incomes are between 100% and 133% of the poverty level.

FAMIS provides a comprehensive benefit package that includes well-child care and preventive services, as well as substance abuse, mental health, dental and vision services. Although FAMIS has cost sharing, FAMIS enrollees enrolled in an MCO will have nominal co-payments. There are no enrollment costs or monthly premiums for FAMIS. Regular and preventive care are provided at no cost to the enrollees.

Some children who live outside managed care service areas access care through FAMIS Fee-For-Service (FFS). In these areas, children can go to any doctor who takes FAMIS.

Consistent with the DMAS managed care program FAMIS enrollees receive services through one of the two delivery systems, the MEDALLION PCCM program, or the Medallion II MCO program. FAMIS offers health benefits through two delivery systems, fee-for-service (FFS) and managed care organizations (MCO). Most FAMIS children receive care through an MCO which has a network of primary care providers (PCPs), specialists, and hospitals. MCOs that provided services to FAMIS eligible children in 2004 include Anthem HealthKeepers Plus, CareNet, Optima, UniCare and Virginia Premier.

The Balanced Budget Act (BBA) of 1997 requires state Medicaid agencies that provide care to Medicaid enrollees through a managed care model to annually evaluate the quality of services furnished by each Managed Care Organization (MCO). However, recognizing the appropriate access to the continuum of quality health services is vital to enable all Medicaid enrollees to achieve their best health states, the Virginia Department of Medical Assistance Services (DMAS) began contracting with an external quality review organization (EQRO) to conduct evaluations of its MCOs prior to the implementation of the Balanced Budget Act (BBA).

DMAS entered into a contract with Delmarva Foundation for Medical Care (Delmarva) to conduct the external quality reviews of the managed care program for the period January 1, 2004 through December 31, 2004. As the EQRO for the Commonwealth of Virginia, Delmarva provides the quality oversight of the integrity of the Medicaid managed care system to ensure that Medicaid MCO enrollees receive quality health care through delivery systems that promote timeliness, accessibility, and coordination of all services.

This report focuses on the focused clinical reviews in the topic areas of well-child visits, appropriate medication for children with asthma, and access to primary care practitioners. The results of these clinical studies are presented in depth in the remainder of this report.

Purpose and Objectives

The purpose of this report is to assess the extent to which FAMIS enrolled children obtain well-child visits according to FAMIS recommended guidelines, receive appropriate medications for those diagnosed with asthma, and have access to primary care providers. This report summarizes the results of Delmarva's analysis of these three areas for children receiving services through the FAMIS program.

Well-Child

The well-child study examines care provided to FAMIS participants in MCOs, FFS and through the PCCM models. A separate analysis is also completed for the PD94 group which includes children not eligible for traditional Medicaid whose family incomes are between 100% and 133% of the poverty level. Specifically, the analysis provides information about the frequency of well-child visits for four age groups of children:

- Those who turned 15 months old in CY 2004 (between January 1, 2004 and December 31, 2004).
- Those who were age 3-6 years old at the end of CY 2004 (December, 31, 2004).
- Those who were age 7-11 years old at the end of CY 2004 (December, 31, 2004).
- Those who were age 12-18years old at the end of CY 2004 (December, 31, 2004).

Well-child visits allow health care providers to detect conditions requiring prompt treatment, provide needed immunizations at recommended intervals, and educate parents about the physical, mental, and nutritional needs of their child.

The specific objectives of this report for the well-child study are to:

- Describe the percentage of well-child visits obtained by 15-month old FAMIS children.
- Describe the percentage of 3 to 6 year old FAMIS children who obtained a well-child visit in a 1 year timeframe.
- Describe the percentage of 7 to 11 year old FAMIS children who obtained a well-child visit in a 1 year timeframe.
- Describe the percentage of 12 to 18 year old FAMIS children who obtained a well-child visit in a 1 year timeframe.
- Compare the observed percentage of age-specific well-child visits according to FAMIS recommended guidelines to national HEDIS Medicaid well-child visit rates.
- Compare the observed percentage of age-specific well-child visits according to FAMIS recommended guidelines by type of FAMIS health insurance program (FFS, MCO and PCCM).

Asthma

Asthma is the most frequently diagnosed chronic disease in children and the most frequent diagnosis listed for children visiting emergency rooms. Low income families are more likely to use the emergency room for acute asthma care and this makes asthma an important area of study for the Medicaid population.

The specific objectives for the asthma study are to:

- Identify the FAMIS enrolled children in two separate age groups: 5 to 9 years and 10 to 17 years of age that have asthma.
- Determine the percentage of the FAMIS enrollees with asthma in each of the two groups who were appropriately prescribed medication for persistent asthma during the study period.
- Provide a comparison and analysis among the various FAMIS delivery systems (FFS, MCO, and PCCM).
- Compare the indicator rates with national Medicaid HEDIS results.

Access to Primary Care Practitioners (PCP)

PCP's often serve as the gateway for children to a particular healthcare delivery system. Access to a PCP is critical for a child's healthcare and developmental needs as well as coordination of their care.

The specific objectives for the Access to Primary Care Practitioners (PCP) study are to:

- Determine the percentage of FAMIS enrollees in age groups 12 to 24 months and 25 months to 6 years that had one or more visits with a PCP during the measurement year;
- Determine the percentage of FAMIS enrollees in age groups 7 through 11 years and 12 through 18 years of age that had one or more visits with a PCP during the measurement year;
- Provide a comparison and analysis among the various FAMIS delivery systems (FFS, MCO, and PCCM)' and
- Compare the indicator rates with national Medicaid HEDIS results.

In addition to the objectives for each of the individual studies, the final objective is to make recommendations to DMAS for future study and program changes that may positively impact the percentage of FAMIS children obtaining (1) recommended well-child visits, (2) appropriate medications for those that have asthma and (3) appropriate access to PCPs.

Section I - Well-Child Study

Introduction

During a well-child visit, preventive care is provided by assessing the physical, behavioral, developmental and emotional well-being of a child. A well-child visit is a critical opportunity for a developmental delay or disability in a child to be detected, which can lead to timely intervention that might lessen the future impact on both the child and family. Well-child visits also allow physicians to promote behaviors conducive to healthy development and give age-appropriate counseling. As traditional childhood diseases become less prevalent, guidelines have become more focused on encouraging pediatricians to also address the parent/child relationship and other psychosocial aspects of development.

Study Population

The eligible population for the first study indicator consisted of members who turned 15 months during the measurement year (CY 2004) and were also continuously enrolled during that year. The eligible population for the second study indicator consisted of members who were three to six years of age as of December 31 of the measurement year and who were continuously enrolled during that year. A gap of no more than 45 days during the continuous enrollment period was allowed for either study group.

Study Indicators

The two study indicators selected include the HEDIS®2005, which are based on calendar year 2004 data, Use of Services indicators described below.

- The percentage of enrolled members who turned 15 months old during the measurement year, who received one, two, three, four, five, or six or more well-child visits with a primary care practitioner during their first 15 months of life.
- The percentage of members who were three, four, five, or six years of age during the measurement year who received one or more well-child visits with a primary care practitioner during the measurement year.

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In addition to these HEDIS 2005 Well-Child indicators, Delmarva also calculated the percentage of enrollees who received one or more well-child visits with a primary care practitioner during the measurement year in the following age groups:

- Ages 3 through 6 years old.
- Ages 7 through 11 years old.
- Ages 12 through 18 years old.

The HEDIS specifications were used to identify the eligible population and calculate the measures for these additional indicators.

Methodology

The study population included all children continuously enrolled in the FAMIS program whose age during CY 2004 (January 1, 2004 – December 31, 2004) was between 15 months and 18 years. For comparability with HEDIS data, HEDIS 2005 technical specifications were used to determine eligibility requirements and to classify children with respect to age. The specifications excluded children who had more than one gap in enrollment during this period or who had one gap of more than 45 days. Program enrollment data provided by DMAS were used to identify members of the study population and to classify them with respect to age and program membership. For children between the ages of 3 and 18 years, age and program membership were established based on their age and program membership as of December 31, 2004. All children that were 15 months old at any point during CY 2004 were placed into the 15-month age group.

The HEDIS hybrid methodology was employed to determine the number of well-child visits within the study period (HEDIS 2005). Both administrative claims data and medical record data were used to count the number of well-child visits for this study. Claims data for FAMIS children were screened to identify all well-child visits each child obtained within the study period. Well-child visits were established using the age appropriate sets of CPT and ICD-9 codes listed in the HEDIS 2005 technical specifications. For those children who did not have a well-child visit according to the administrative claim data, a second screening was conducted utilizing medical record review for determining well-child visits within the study timeframe. For the 15-month old group, the total number of well-child visits, from one month after birth through 15-months of age, was counted. For older age groups, children were classified as having received (or not received) one or more well-child visits between January 1, 2004 and December 31, 2004 (annual measure).

Table 1 provides the CPT and ICD-9 codes used to identify well-child visits in the administrative data.

Table 1. Well-Child visit codes

Age Group	CPT Codes	ICD-9 Codes
1-15 months	99381, 99382, 99391, 99392, 99432	V20.2, V70.3, V70.5, V70.6, V70.8, V70.9
3-18 years	99382–99385, 99392–99395	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

For both indicators, the primary care practitioner does not have to be the practitioner assigned to the child. Primary care practitioners are defined as physicians and non-physician, mid-level practitioners whose primary or secondary specialty are of the primary care specialties and defined by the MCO as primary care practitioners.

The indicator specifications also allow the MCO to count visits to physician assistants, nurse practitioners in primary care practitioner offices, even if the practitioner is not listed as a primary care practitioner in the MCO directory, as long as the practitioner provided any service specified in the CPT and/or ICD-9-CM codes for this measure.

Inpatient, emergency room, and specialist visits are not counted in this measure. The intent is to capture comprehensive well-child visits only.

Medical record positive numerator hits were determined through notes in the medical record that included indications of a visit to a primary care practitioner, the date of that visit and documentation indicating a health and developmental history (physical and mental), a physical exam, and health education/anticipatory guidance. Table 2 provides the medical record documentation required for a positive numerator hit.

Table 2. Well-Child visit documentation in the medical record

Medical Record	Documentation from the medical record must include a note indicating a visit with a primary care practitioner, the date the well-child visits occurred and evidence of all of the following: • A health and developmental history (physical and mental) • A physical exam • Health education/anticipatory guidance

For the first study indicator, seven separate numerators were calculated, corresponding to the number of members who received zero, one, two, three, four, five, or six or more well-child visits with a primary care practitioner during their first 15 months of life. To count toward this measure, the well-child visit must occur with a primary care practitioner. A child should be included in only one numerator (e.g. a child receiving six well-child visits will not be included in the rate for five or fewer visits).

One numerator was calculated for the remaining indicators (three to six years, seven to 11 years, and 12 through 18 years) for all enrollees in the study population who had at least one well-care visit with a primary care practitioner during the measurement year.

Findings

The findings for the well-child indicators are summarized in Figure 2 and Tables 4 through 6, NCQA's HEDIS 2005 Medicaid rates, which are based on calendar year 2004 data, were used as comparison measures for the analysis.

Standards for well-child care vary for children of different ages; the FAMIS guidelines are described in Table 3.

Table 3. FAMIS Well-Child Visit Guidelines

Child's Age	Number of Well-Child Visits By Age
1 Month	1
2 Months	2
4 Months	3
6 Months	4
9 Months	5
12 Months	6
15 Months	7
18 Months	8
2 – 6 Years	Annually
7 – 18 Years	Biennially

Based on the FAMIS guidelines and utilizing the HEDIS 2005 hybrid methodology, Delmarva completed an analysis on the number of well-child visits recorded for children age 15 months during the study year of CY 2004. The results are as follows.

Table 4. Frequency/Percentage of Well-Child Visits for FAMIS Enrollees Age 15 Months

Number of Visits	Numerator	VA FAMIS Rate CY 2004	National Medicaid HEDIS 2005*			
			Mean	50th Percentile	75th Percentile	90th Percentile
6 or More	84	50.9%	46.8%	48.5%	56.6%	67.7%
5	15	9.1%	18.3%	18.9%	22.3%	25.3%
4	27	16.4%	12.3%	12.7%	15.2%	17.3%
3	15	9.1%	7.5%	7.3%	9.3%	11.3%
2	7	4.2%	4.9%	4.1%	6.4%	9.9%
1	9	5.5%	4.1%	2.4%	4.2%	8.1%
0	8	4.8%	6.0%	2.0%	3.7%	11.6
Total	165	100%	100%	N/A	N/A	N/A

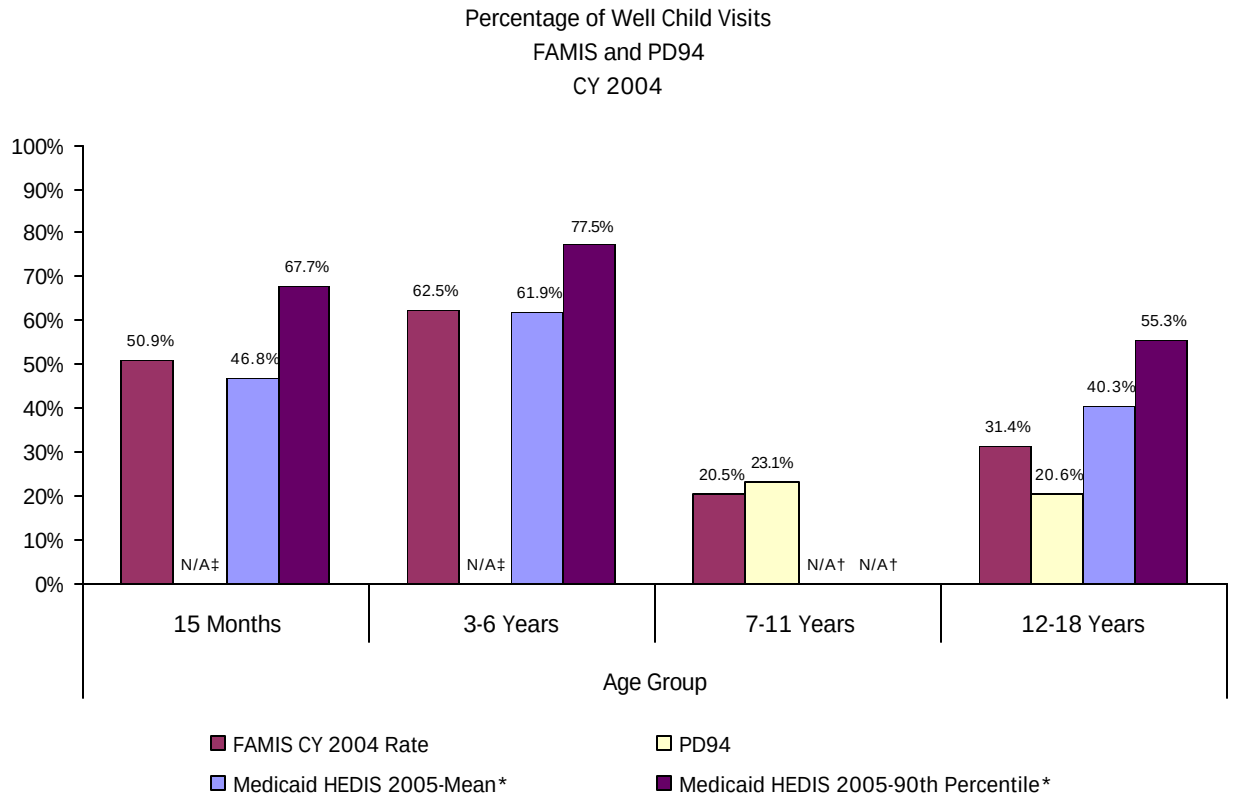
*HEDIS 2005 rates are based on CY 2004 data

According to the FAMIS guidelines, by age 15 months, a child should have seven documented well-child visits. As indicated in the table above, 50.9% of the children age 15 months received six or more well-child visits in the study year. This compares favorably to the National Medicaid HEDIS 2005 mean rate of 46.8%. The FAMIS well-child visit indicator rate for six or more visits also exceeded the National Medicaid HEDIS 50th percentile rate of 48.5%.

Only eight children (4.8%) received no well-child visits at all in the review year. This rate is below the National Medicaid HEDIS 2005 rate which is positive in that this means a small percentage of FAMIS enrolled children in this age group received no well-child visits at all in the review year.

Figure 2 presents the well-child visit rates by age group for FAMIS and PD94.

Figure 2. Well-Child Visit Rates by Age Group



‡PD94 rate not measured for 15 months or 3-6 years
†HEDIS Benchmark Not Available for 7-11 age group

*Medicaid HEDIS 2005 measures represent 2004 reported data.

Note: Well-Child Visit rate from 15 month age group is based on 6+ visits; The Well-Child Visit rate for 3-18 year age group is based on at least one visit.

For the 325 FAMIS enrollees in the 3-6 year old study population, 62.5% had one or more well-child visits in the study period. This compares favorably to the National Medicaid HEDIS 2005 mean rate of 61.9%. While the rates for these two study populations compare favorably with the National Medicaid 2005 mean, both are below the National Medicaid HEDIS 2005 50th percentile for their respective measures. Of the 403 enrollees age 7-11 years, 20.5% had a well-child visit. National Medicaid HEDIS 2005benchmarks for this age group are unavailable as HEDIS does not include this age group in its specifications. For the 404 enrollees age 12-18 years, 31.4% had a well-child visit. This falls below the National Medicaid HEDIS 2005 mean rate of 40.3% for 12-18 year olds.

Table 5. FAMIS Enrollees with at Least One Well-Child Visit by Age Group by Delivery System

CY 2004 FAMIS	Age Group		
	3 to 6 Years	7 to 11 Years	12 to 18 Years
MCO	65.6%	27.0%	36.8%
FFS	58.6%	17.2%	30.6%
PCCM	63.8%	17.2%	26.9%
All	62.5%	20.5%	31.4%

Note: 15 month age group not included in PD94 population

As the PD 94 population does not include 15 month or 3-6 years age group, Delmarva did not calculate rates for these groups. Of the 403 enrollees, age 7-11 years, 23.1% had at least one well-child visit. National Medicaid HEDIS benchmarks for this age group are unavailable. For the 404 enrollees, age 12-18 years, 20.6% had a well-child visit. This falls below the Medicaid HEDIS 2005 mean rate of 40.3% for 12-18 year olds.

Table 6. Well-Child Visit PD94 Rates by Delivery System

CY 2004 PD94	Age Group	
	7 to 11 Years	12 to 18 Years
MCO	30.4%	29.0%
FFS	19.4%	12.7%
PCCM	19.4%	20.1%
All	23.1%	20.6%

Note: Insufficient sample size for 15 month and 3-6 years age groups

Conclusions and Recommendations

Overall the well-child rates for children 15 months of age and 3 to 6 years were slightly higher than the Medicaid HEDIS 2005 rates. However, the rates for both age groups were well below the Medicaid HEDIS 2005 90th percentile.

Improving the rate for well-child visits has been a challenge for most state Medicaid agencies. Visits may be coded as a well-child visit but not contain all the required components, and even with these visits included, rates usually fall far below established recommendations. Nevertheless, for any improvement effort, the goal must be to improve the rate and the quality of well-child visits.

Multiple barriers have been identified by providers and families for achieving better rates:

Providers

- Missed opportunities when children in for sick visits because of time limitations.
- No system for tracking, identifying children delinquent for visits, contacting for appointments, or follow-up for broken appointments.
- Reimbursement rates are not adequate to cover cost of screenings.

Families

- Not aware of value of preventive visits and do not perceive children as having a problem.
- Have no transportation.
- Difficulty getting away from work and no appointments after-hours.

Many quality improvement efforts for this problem have not produced significant change in rates because all barriers are not identified and interventions were too narrow. For example, if providers perceive the reimbursement rate for these visits do not cover their costs, it is unlikely that strategies aimed to improve provider practice will be successful.

A complex issue such as this is often a good choice for a statewide quality improvement project for a Medicaid Managed Care program. Using the collaborative approach for identifying barriers and prioritizing interventions can achieve greater commitment to improvement. Following a quality improvement process, the Plan, Do, Study, Act (http://www.saferpak.com/pdsa.htm) monitor and adjust interventions as needed prevents prolonging efforts that are not working. This approach can also be used by a health plan for its provider network. The critical stakeholders for either collaborative approach are providers.

Section II - Asthma Study

Introduction

Asthma is the most frequently diagnosed chronic disease in children and the most frequent diagnosis listed for children visiting emergency rooms. Low income families are more likely to use the emergency room for acute asthmatic care and this makes asthma an important concern for Medicaid programs.

Two types of medications are used for asthma – rescue and controller medications. Rescue medications are taken after an asthma attack has begun to stop the symptoms. Controller medications are for long-term control of persistent asthma. These medications help reduce the inflammation in the lungs that leads to asthma attacks. Controller medications should be taken every day whether a person is symptomatic or not in order to prevent attacks. Unfortunately, these drugs are not always prescribed and children use only rescue medications after symptoms of an attack have started.

Uncontrolled asthma can lead to emergency room visits and hospitalizations. Despite national clinical guidelines that recommend the use of controller medications by people with persistent asthma, studies have shown that many children with asthma do not receive these drugs. Due to the number of children with asthma, the lack of asthma control, and the expense associated with severe, acute attacks, monitoring for use of controller medications in children with asthma has become a priority among health plans.

This study will examine the use of appropriate asthma medications in children diagnosed with persistent asthma during measurement year CY2004. This measure evaluates if children with persistent asthma are prescribed medications that are acceptable as primary therapy for long-term asthma control. While there are a number of acceptable therapies for people with persistent asthma, the best available evidence indicates that inhaled corticosteroids are the preferred primary therapy. For children with moderate-to-severe asthma, inhaled corticosteroids are the only recommended primary therapy.
http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm

Study Population

The study population is defined as children having persistent asthma who, during the *year prior to the measurement year (CY 2003),* had any of the following:

- At least one Emergency Department (ED) visit based on the visit codes below with asthma (ICD-9 code 493) as the principal diagnosis.
- At least one acute inpatient discharge based on the visit codes below, with asthma as the principal diagnosis.
- At least four outpatient asthma visits based on the visit codes with asthma as one of the listed diagnoses and at least two asthma medication dispensing events.
- At least four asthma medication dispensing events (i.e., an asthma medication was dispensed on four occasions).

For a member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed, the member must:

- Meet any of the other three criteria stated above, *or*
- Have at least one diagnosis of asthma in any setting in the year prior to the measurement year.

Children were eligible for the study population if they had continuous enrollment in both the measurement year (CY 2004) and the year previous to the measurement year (CY 2003) with a gap in enrollment of no more than 45 days during each year of enrollment. The anchor date for enrollment was December 31, 2004. Children diagnosed with emphysema and Chronic Obstructive Pulmonary Disease (COPD) were excluded from the study population.

According to best available evidence and consistent with the National Heart, Lung and Blood Institute (NHLBI) National Asthma Education and Prevention Program (NAEPP) Guidelines for the Diagnosis and Management of Asthma, the following five classes of long-term control medications include the following medications:

- Cromolyn sodium,
- Inhaled corticosteroids,
- Leukotriene modifiers,
- Methylxanthines, and
- Nedocromil

These five classifications of medication are considered preferred therapy for asthma treatment and are counted in the measure's numerator. The last class of medication, long-acting, inhaled beta-2 agonists, is considered an add-on therapy, and does not count towards the numerator count. A dispensing event for a particular medication is one prescription of an amount lasting 30 days or less.

Study Indicators

The study indicator is the percentage of the eligible population ages 5 to 9 years and 10 to 17 years who were appropriately prescribed medication for persistent asthma during the year. The denominator consists of the eligible population. The numerator includes members who were appropriately prescribed with one of the five classes of long-term medications described above that are considered the preferred therapy.

Methodology

The HEDIS 2005 administrative methodology was used to calculate the indicators described above for the 5 to 9 and 10 to 17 year age groups. The numerator and denominator were defined as described above. Table 1 includes the list of asthma medications used to define an appropriate medication for the persistent asthma study population. Table 2 includes the CPT and ICD9 codes used to determine emergency department and inpatient asthma encounters used to define the study population according to HEDIS specifications.

Table 1. Asthma Medications

Description	Prescription
Preferred therapy	• Cromolyn Sodium • Inhaled Corticosteroids • Leukotriene Modifiers • Methylxanthines • Nedocromil
Add-on therapy	• Long-acting, Inhaled Beta-2 Agonists

Table 2. Codes to Identify Emergency Department and Inpatient Asthma Encounters

Description	CPT Codes	UB-92 Revenue Codes
Acute Inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291, 99292, 99356, 99357	10X-16X, 20X-22X, 72X, 80X, 987
ED Services	99281-99285	450, 451, 452, 459, 981
Outpatient Visit	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99271-99275	456, 510, 515-517, 520, 521, 523, 526, 76X, 770, 779, 982, 983, 988

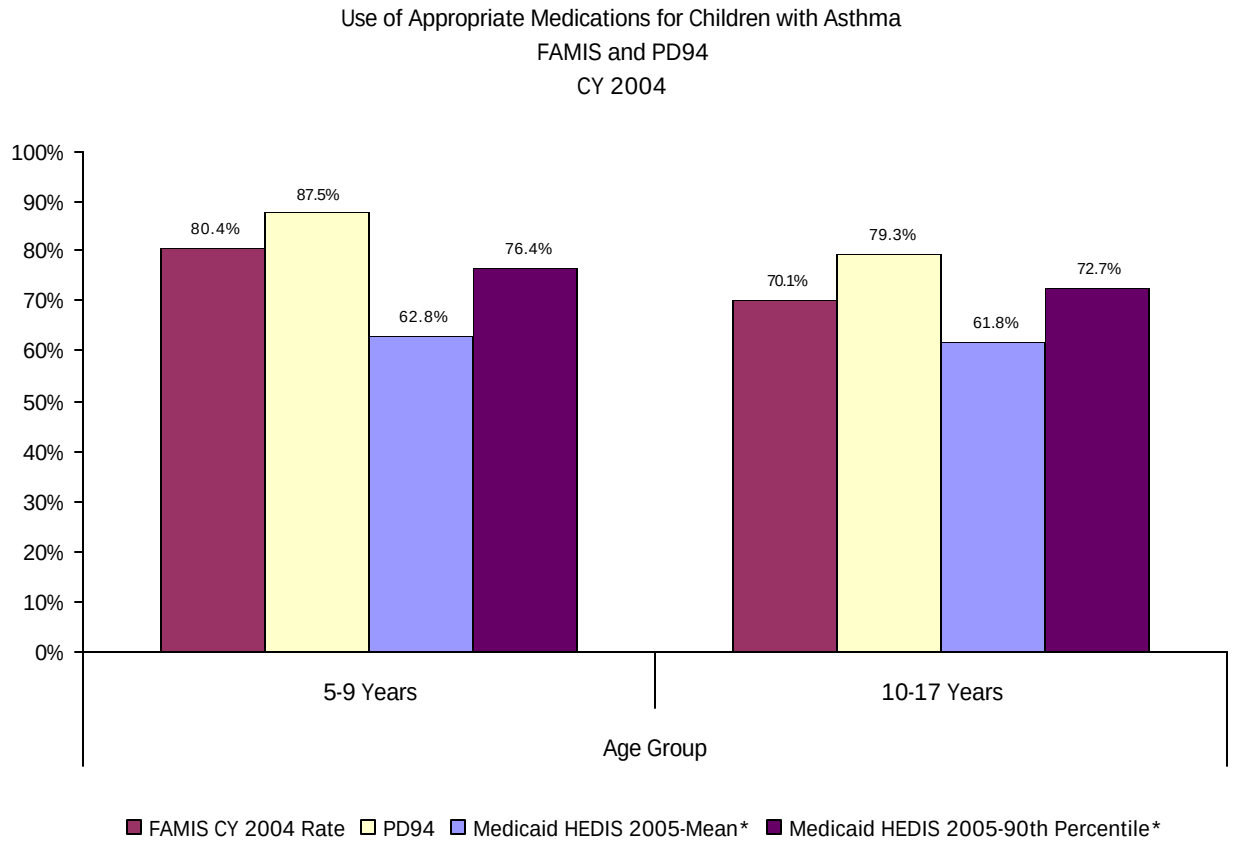
Findings

For the FAMIS enrollees, 135 children age 5-9 years, 80.4% were appropriately prescribed medication for persistent asthma. This compares favorably with the National Medicaid HEDIS 2005 mean of 62.8% and is above the National Medicaid HEDIS 2005 90th percentile rate of 76.4%. For the 169 enrollees, age 10-17 years, 70.1% were appropriately prescribed medication for persistent asthma. This compares favorably with

the National Medicaid HEDIS 2005 mean of 61.8%, however this rate falls below the National Medicaid HEDIS 2005 90th percentile of 72.7% by 2.6% percentage points.

Figure 2 presents the use of appropriate medication rates for children with asthma by age group for FAMIS and PD94.

Figure 2. Use of Appropriate Medications for Children with Asthma



*National Medicaid HEDIS 2005 measures represent 2004 reported data

Table 3. Use of Appropriate Medications for Children with Asthma, Virginia FAMIS CY 2004

Measure	Population	Numerator/ Denominator	Rate	National Medicaid HEDIS 2005*	
				Mean	90th Percentile
Use of Appropriate Medications For Children with Asthma	5-9 Years	135/168	80.4%	62.8%	76.4%
	10-17 Years	169/241	70.1%	61.8%	72.7%

*National Medicaid HEDIS 2005 measures represent 2004 reported data

Table 4. Use of Appropriate Medications for Children with Asthma, FAMIS Population

CY 2004 FAMIS	Age Group	
	5 to 9 years	10 to 17 Years
MCO	80.7%	67.5%
FFS	78.6%	88.9%
PCCM	80.0%	69.6%
All	80.4%	70.1%

Both age groups for the PD94 population exceeded the National Medicaid HEDIS 2005 mean and 90th percentile's for their age group. For the 32 enrollees, age 5-9 years, 87.5% were appropriately prescribed persistent asthma medication. This rate exceeds the National Medicaid HEDIS 2005 mean of 62.8% and the National HEDIS 2005 Medicaid 90th percentile of 76.4%. Of the 121 enrollees, age 10-17 years, 79.3% were appropriately prescribed persistent asthma medication. This rate also exceeds the National Medicaid HEDIS 2005 mean of 61.8% and the National HEDIS 2005 Medicaid 90th percentile of 72.7%.

Table 5. Use of Appropriate Medications for Children with Asthma, PD94 Population CY 2004

Measure	Population	Numerator/ Denominator	Rate	National Medicaid HEDIS 2005*			
				Mean*	50th Percentile	75th Percentile	90th Percentile
Use of Appropriate Medications For Children with Asthma	5-9 Years	28/32	87.5%	62.8%	66.6%	72.3%	76.4%
	10-17 Years	96/121	79.3%	61.8%	64.1%	69.5%	72.7%

*National Medicaid HEDIS 2005 measures represent 2004 reported data

Table 6. Use of Appropriate Medications for Children with Asthma, PD94 Population CY 2004 by Delivery System

CY 2004 PD94	Age Group	
	5 to 9 years	10 to 17 Years
MCO	88.9%	76.6%
FFS	n/a	75.0%
PCCM	100%	91.3%
All	87.5%	79.3%

Conclusions and Recommendations

The use of appropriate medications for children diagnosed with persistent asthma for the Virginia 5 to 9 year old FAMIS population exceeded both the National Medicaid HEDIS 2005 mean and 90th percentile. The rate of appropriate use of asthma medications for the 10 to 17 year old population also exceeded the National Medicaid HEDIS 2005 mean and was slightly less than the National Medicaid HEDIS 90th percentile. The rate of appropriate medication use in the persistent asthma population was comparable across the MCO, FFS, and PCCM healthcare delivery systems for the FAMIS population, 5 to 9, and 10 to 17 year old age groups. One notable exception was the FFS 10 to 17 year old age group which was considerably higher than the other two healthcare delivery systems for the FAMIS population. Alternatively, the PCCM program was higher than the other two delivery systems for the PD94 population.

When rates for appropriate asthma medication are as high as those found in this study, most providers are aware of medication guidelines and using them. A strategy for further improvement might involve Medicaid health plans determining if certain providers within their networks are more likely to have children in their panel with inappropriate asthma medications. Feedback to providers about their performance compared to their peers is a proven strategy for changing provider practice behavior. This more focused intervention approach can be more efficient and effective when rates are this good and the goal is for every child to have appropriate asthma medication.

Section III - Access to Primary Care Practitioners Study

Introduction

The American Academy of Pediatrics recommends that children should visit their pediatrician for a well-child check-up as a newborn, by one month, at two, four, six, nine, twelve, fifteen, eighteen, and twenty-four months, and once a year from ages three to twenty-one. During the preschool years, children are more likely to adhere to this schedule, but well-child visits decrease as school age children get older. Unfortunately, older children experience problems after starting school that benefit from early detection and management by their healthcare provider: school problems including learning disabilities and attention difficulties, mood and anxiety disorders, alarming increase in adolescent suicide and homicide, firearms in the home, school violence, drug and alcohol abuse, increased sexual activity and the problems associated, and lifestyle choices leading to obesity. Immunizations are also recommended during adolescence.

Because well-child visits are scheduled less frequently for school age children, providers often see this group only for acute care visits. Although acute care visits may allow little time for preventive care, they do provide an opportunity for the pediatrician to do some screening for problems and offer anticipatory guidance. For this reason, children who are at least seen by their providers once a year for acute care are more likely to have problems detected than children who do not see a health professional.

Study Population

The eligible study population includes enrollees ages 12 to 24 months and 25 months to 6 years who were continuously enrolled during the measurement year (CY 2004) and enrollees ages 7 to 11 years and 12 to 19 years who were continuously enrolled during both the measurement year and the year prior to the measurement year. Enrollees, ages 12 to 24 months and 25 months to 6 years were allowed no more than one enrollment gap of 45 days during the measurement year. Enrollees, ages 7 to 11 and 12 to 19 years were allowed no more than one enrollment gap of 45 days during each year of continuous enrollment.

Study Indicator

- HEDIS 2005 Access/Availability of Care measures were selected for the Access to PCP Study. The selected indicators and age groups include: study. Children 12 to 24 months and 25 months to 6 years of

age who had a visit with an MCO primary care practitioner during the measurement year contributed to the numerator.

- Children 7 to 11 and adolescents 12 to 19 years of age who had a visit with an MCO primary care practitioner during the measurement year or the year prior to the measurement year also contributed to the numerator.
- The denominator for the indicator included the total eligible population.

Methodology

The methodology used in this study adhered to the HEDIS 2005 technical guidelines. Indicators were stratified by the following age groups: 12 to 24 months, 25 months to 6 years, 7 to 11 years and 12 to 19 years. To count toward the measure (i.e. a positive numerator event), the visit must have occurred with a primary care practitioner. Primary care practitioners are defined as physicians and nonphysician primary care practitioners whom members are able to select as primary care practitioners and who are defined by the healthcare delivery system as primary care practitioners. A claim/encounter with any CPT code or ICD-9-CM code presented in Table 1 is counted as a visit with a primary care practitioner. Inpatient procedures, emergency department and specialist visits were excluded.

Table 1: Codes for Identifying Ambulatory or Preventive Care Visits

Description	CPT Codes	ICD-9-CM Revenue Codes
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245	
Home services	99341-99350	
Preventive Medicine	99381-99385, 99391-99395, 99401-99404, 99411-99412, 99420, 99429	
Other evaluation and management services	99499	
General medical examination		V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Findings

All age groups of the FAMIS enrollees exceeded the Medicaid HEDIS 2005 mean for their respective age group category. Of the 503 children age 12-24 months, 95.1% had a visit with an MCO primary care practitioner. This compares favorably with the National Medicaid HEDIS 2005 mean of 91.8%. This measure also exceeds the National HEDIS 2005 50th percentile of 94.6%, but falls short of the National Medicaid HEDIS 2005 75th percentile rate of 97.1%.

For the 4066 enrollees, age 25 months- 6 years, 86.1% had a visit with an MCO primary care practitioner. This compares favorably with the Medicaid HEDIS 2005 mean of 81.6%. The rate for this age group also exceeds the National Medicaid HEDIS 2005 50th percentile rate of 84.6%, and just falls short of the 75th percentile rate of 87.9%.

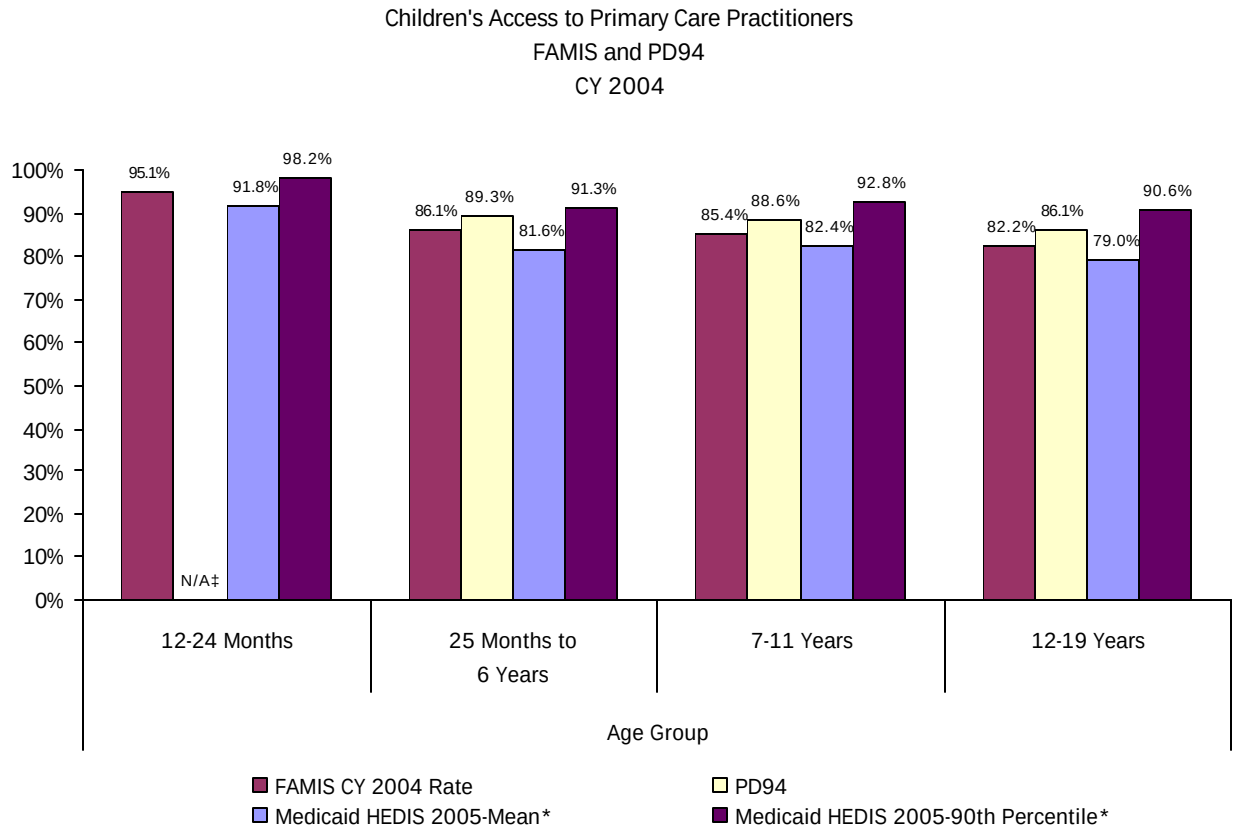
For the 2490 enrollees, age 7-11 years, 85.4% had a visit with an MCO primary care practitioner. This compares favorably with the Medicaid HEDIS 2005 mean of 82.4%. The indicator rate for this age group exceeds the National Medicaid HEDIS 2005 50th percentile rate of 83.8%, but does not exceed the National HEDIS 2005 Medicaid 75th percentile rate of 89.6%

Of the 3493 enrollees, age 12-19 years, 82.2% had a visit with an MCO primary care practitioner. This compares favorably with the Medicaid HEDIS 2005 mean of 79.0%. The indicator rate for this age group exceeds the National Medicaid HEDIS 50th percentile rate of 81.9%, but falls short of the National Medicaid HEDIS 2005 75th percentile rate 88.3%.

It is noteworthy that the indicator rate for all age groups exceeded the National Medicaid HEDIS 2005 mean and 50th percentiles. None of the age groups met or exceeded the National Medicaid HEDIS 2005 75th or 90th percentile rates.

Figure 3 presents the access to primary care practitioners rate by age group for FAMIS and PD94.

Figure 3. Children's Access to Primary Care Practitioners by Age Group



‡PD94 rate not measured for 23-24 months

*Medicaid HEDIS 2005 measures represent 2004 reported data

Table 2. Children's Access to Primary Care Practitioners by Age Group, FAMIS CY 2004

Measure	Population	Numerator/ Denominator	Rate	National Medicaid HEDIS 2005*			
				Mean*	50th Percentile	75th Percentile	90th Percentile
Children's Access to Primary Care Practitioners	12-24 Months	503/529	95.1%	91.8%	94.6%	97.1%	98.2%
	25 Months-6 Years	4066/4724	86.1%	81.6%	84.6%	87.9%	91.3%
	7-11 Years	2490/2916	85.4%	82.4%	83.8%	89.6%	92.8%
	12-19 Years	3493/4250	82.2%	79.0%	81.9%	88.3%	90.6%

*Medicaid HEDIS 2005 measures represent 2004 reported data

Table 3. Children and Adolescents' Access to Primary Care Practitioners, FAMIS by Delivery System

CY 2004 FAMIS	Age Group			
	12-24 months	25 months to 6 years	7 to 11 Years	12 to 19 Years
MCO	95.3%	85.6%	83.9%	81.0%
FFS	93.4%	88.2%	92.1%	87.7%
PCCM	100%	93.3%	95.3%	87.0%
All	95.1%	86.1%	85.4%	82.2%

Tables 4 and 5 describe the findings for the PD94 group. PD 94 population includes children age of 6-18 years; Delmarva calculated rates for this groups.

There were 317 eligible enrollees for the 25 months- 6 years age group. Of these children, 89.3% had a visit with an MCO primary care practitioner. This exceeds the National Medicaid HEDIS 2005 mean (81.6%), the 50th percentile (84.6%) and the 75th percentile (87.9%).

Of the 954 enrollees, age 7-11 years, 88.6% had a visit with an MCO primary care provider. This rate exceeds the National Medicaid HEDIS 2005 mean (82.4%), the 50th percentile (83.8%), and falls just short of the 75th percentile rate of 89.6%

For the 1673 enrollees, age 12-19 years, 86.1% had a visit with and MCO primary care provider. This exceeds the Medicaid HEDIS 2005 mean (79.0%), and the 50th percentile (81.9%), but falls short of the 75th percentile (88.3%). None of the PD94 age groups met the Medicaid HEDIS 2005 90th percentile for their groups.

Table 4. Children's Access to Primary Care Practitioners by Age Group, PD94 CY 2004

Measure	Population	Numerator/ Denominator	Rate	National Medicaid HEDIS 2005*			
				Mean*	50th Percentile	75th Percentile	90th Percentile
Children's Access to Primary Care Practitioners	25 Months-6 Years	283/317	89.3%	81.6%	84.6%	87.9%	91.3%
	7-11 Years	845/954	88.6%	82.4%	83.8%	89.6%	92.8%
	12-19 Years	1441/1673	86.1%	79.0%	81.9%	88.3%	90.6%

*Medicaid HEDIS 2005 measures represent 2004 reported data

Table 5. Children and Adolescents' Access to Primary Care Practitioners, PD94

CY 2004 PD94	Age Group		
	25 months to 6 years	7 to 11 Years	12 to 19 Years
MCO	72.2%	87.4%	85.4%
FFS	100%	90.2%	80.4%
PCCM	91.2%	94.2%	91.2%
All	89.3%	88.6%	86.1%

Note: The 12 to 24 month age group is not included in the PD94 population

Conclusions and Recommendations

Access to a primary care physician for all age groups of the FAMIS enrollees exceeded the Medicaid HEDIS 2005 mean but failed to reach the Medicaid HEDIS 90th Percentile. The two younger age groups were closer to the 90Th percentile than the two older groups, and this is a typical finding across Medicaid programs. School age children are more likely to have a health visit only when ill or having a problem.

With these rates, one might assume that children and youth have access to providers when they are ill or seek care. Increasing this rate, then would depend upon increasing the well-child visit rate. Two primary components for such a strategy are needed.

1) Motivating families to seek well-child visits for their children and adolescents.
   a) Providers discuss value of visits with parents when children are in for acute care.
   b) Health Plans promote the value of the visits in their materials to members.

2) Tracking children for completion of well-child visits
   a) Providers and/or health plans have a system to detect those delinquent for visits
   b) Providers and/or health plans make significant efforts to contact families and schedule appointments when needed. Medicaid families may be difficult to contact so efforts have to be multiple and varied.

Often these strategies gain some improvement, but additional effort may be needed. The next step might be to ask identified families whose children have not had a visit, why no appointments were made. This would potentially provide a better barrier analysis and ultimately successful interventions to address them.